THE UNIVERSITY of TEXAS
HEALTH SCIENCE CENTER
AT HOUSTON

UTHSC MRI Center

6431 Fannin, G.605 Houston, TX 77030
Tel: (713)500-6916 Fax: (713)500-0698

Label

EXAMINATION ORDER FORM

SCAN TIME/DATE: _____ NAME (Study name or Code number):_____

PATIENT NAME:_____ PT ID# _____

PATIENT D.O.B.: _____ AGE: _____ GENDER: MALE FEMALE

PATIENT IS: RIGHT HANDED or LEFT HANDED HEIGHT: _____ WEIGHT: _____

REFERRING PHYSICIAN: Yoshor PHONE: (713)798-4696 FAX: (713)798-3739

DIAGNOSIS: epilepsy

PLEASE CHECK EXAM REQUIRED BELOW

MRI of Head & Neck

_____ Temporomandibular Joint
_____ Orbits/ Face/ Neck
_____ Head, Attention to IACS
X Brain Without Contrast
_____ Brain With & Without Contrast*
_____ Pituitary With & Without Contrast*

MRI of Spine

_____ Cervical Without Contrast
_____ Cervical Spine With & Without Contrast*
_____ Thoracic Without Contrast
_____ Thoracic With & Without Contrast*
_____ Lumbar Without Contrast
_____ Lumbar With & Without Contrast*

MRA

_____ Head
_____ Neck

MRI of Extremities

_____ LEFT Knee
_____ RIGHT Knee

MRI of Abdomen & Pelvis

_____ Abdomen
_____ Pelvis

Cardiac MRI

_____ Heart Without Contrast
_____ Heart With & Without Contrast

***REQUIRED* INFORMATION FOR ALL CONTRAST ORDERS:**

- Contrast Injection X 1 dose via IVP / Injector (dose 0.2ml/kg with Max dose of 20ml)
- Patient who has a history of Diabetes Mellitis and/or Renal disease will need a STAT Creatinine done (if no serum creatinine has been performed in the last 2 weeks.)

MD Signature: _____ Date:_____

Special Instructions: For billing inquiry, please contact Dr. Yoshor's secretary, Pam Wilson, at (713)798-3848 or pmwilson@bcm.tmc.edu
Dept of Neurosurgery, Baylor College of Medicine, 6560 Fannin, Suite 900
Houston, TX 77030

PRIMARY INVESTIGATOR SIGNATURE: Daniel Yoshor M.D.

ACCOUNT NUMBER FOR CHARGE: NINDS 5K08NS04053-05

**Acct number MUST be filled out prior to scanning, or patient/subject will not be scan.*

Rev. 07/03/09